

WAKE FOREST BAPTIST MEDICAL CENTER MEDICAL STAFF RULES AND REGULATIONS

A. Admission & Discharge of Patients

1. A patient may be admitted to the hospital only by a member of the medical staff who has admitting privileges. All admissions, except medical emergencies, are to be approved by the preadmissions/admissions office.
2. A member of the medical staff shall be responsible for the medical care and treatment of each patient in the hospital, for the prompt completion of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient. Whenever these responsibilities are transferred to another staff member, the attending service must enter an order indicating the desired transfer. In the case of House Officers, the attending practitioner will be the supervising practitioner.
3. Practitioners admitting emergency cases shall be prepared to justify to the Medical Executive Committee that the admission was an emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's chart as soon as possible after admission.
4. The attending practitioner will follow the Utilization Management Plan and is required to document the need for ongoing hospitalization in the medical record. The Department of Care Coordination will contact the attending for clarification if the record does not support the need for inpatient care based on standard screening criteria. Cases may be referred to a Physician Advisor for review if there are questions about the need for continued inpatient status.
5. Patients shall be discharged only on a written order of the attending practitioner or his/her designee with completion of an electronic or paper Discharge Order and Summary Form. Should a patient leave the hospital against the advice of the attending practitioner or without proper discharge, a notation of the incident shall be made in the patient's medical record.
6. It is the duty of all medical staff to ensure that the surviving family's legal right to donate tissue and/or organs is respected, in keeping with federal and state law. All patients in the process of being declared dead by neurological criteria (brain dead) or for whom death is imminent or whom death has occurred shall be referred to Carolina Life-Care as prospective organ-tissue donors. It is the duty of the attending practitioner to insure that donation options are preserved by

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appropriate patient management. Because criteria for donation are highly variable, each potential donor will be evaluated by Carolina Life-Care, the organ/tissue donor program of Wake Forest Baptist Medical Center.

7. An autopsy may be performed only with legally valid consent or by order of the Medical Examiner. All autopsies shall be performed by the hospital Pathology Department.

B. Ambulatory Care

1. Emergency Department Services

The Emergency Department shall be operated under the direction of a Nurse Unit Manager and a Medical Director who is a member of the Active Medical Staff. Consultation shall be available at all times from each service. It is the responsibility of the physician on duty in the Emergency Room to make such reports to proper authorities as are required and to meet all existing state and local laws.

2. Outpatient Department

Each outpatient clinic will be operated under the direction of a Nurse or Business Manager and a Medical Director who is a member of the Active Medical Staff. Proper and complete medical records shall be kept on all patients seen in the outpatient department.

C. Emergency Medical Treatment and Active Labor Act (EMTALA)

1. The Medical Staff of Wake Forest Baptist Medical Center acknowledges and intends to comply with all of the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA).
2. These Medical Staff Rules and Regulations incorporate by reference WFBMC's policies and procedures for EMTALA, including the obligation to perform medical screening examinations by qualified medical personnel (QMP) upon any individual who comes by him or herself (or with another person) to the emergency department and a request is made on the individual's behalf for examination or treatment of a medical condition. At the Hospital, QMP to perform medical screening examinations (MSE) for purpose of determining whether an emergency medical condition (EMC) exists are members of the Medical Staff at Wake Forest Baptist Medical Center. Under the Medical Staff Bylaws, QMP are members of the Medical Staff or their designees. Designees are: House Officers or Midlevel Providers, (Section I of these Rules and Regulations), if so approved by a clinical director of a clinical department.
3. When a physician is identified as being "on-call" to the emergency department for a

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given specialty, it shall be the duty and the responsibility of that physician to assure the following:

- a. Immediate availability, to the emergency department physician for his/her scheduled "on-call" period, or to secure a qualified alternate in the event he/she is temporarily unavailable.
- b. Arrival or response to the Emergency Department should be within thirty (30) minutes. The emergency department physician shall note the time of notification and the response (or transfer) time in the emergency department record. The emergency department physician, in consultation with the on-call physician, shall determine whether the individual's condition requires the on-call physician to see the individual immediately. The determination of the emergency department physician shall be controlling in this regard.

D. General Conduct of Care

1. A general consent form signed by or on behalf of every patient admitted to the hospital, should be obtained before admission.
2. All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia, National Formulary, American Hospital Formulary Service, A.M.A. Drug Evaluations, or those released by the F.D.A. for general medical usage. Drugs for clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Food & Drug Administration.
3. The consulting medical staff shall consist of qualified physicians or dentists or other biomedical scientists who, on special occasions, may be invited to visit a patient in the hospital, advise the physician responsible for the care of the patient and observe the course of treatment, provided the Chief of the appropriate department or their designee gives permission. Such a consultant shall not assume primary responsibilities for the patient. A member of the medical staff inviting such a consultant shall notify the chief of the appropriate department in each case and shall assume responsibility for adherence to this rule. In addition, the consultant will be required to comply with all applicable rules and regulations of Wake Forest Baptist Medical Center pertaining to confidentiality of medical records.

E. House Officers

1. All house officers must meet licensure requirements of the State of North Carolina.

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2. All house officers must secure legal authorization for prescription of regulated drugs.
4. House officers will participate in the care of patients under the supervision of the responsible practitioner.
5. House officer participation does not preclude documentation or order writing by the medical staff.

F. Acting Interns (Advanced Clinical Clerks)

1. Eligibility - Medical students serving as Acting Interns must have completed the required clinical clerkships of the Wake Forest School of Medicine curriculum or its equivalent. Each appointment must be approved by the Chief of the appropriate service.
2. Duties & Responsibilities - The duties and responsibilities of the Acting Interns are those assigned by the Chief of the appropriate service and, in general, are similar to those of a first-year house officer on that service. It is important that the Acting Intern function with close supervision by the resident and attending staff, with the individual functions delineated and approved by the Chief of the service.
3. Writing of Orders - Orders may be written by the Acting Intern under conditions defined by the Chief of the service. It is incumbent upon the Acting Intern and his immediate supervising physician (resident or attending) to determine that all medication and non-routine orders be appropriate and indicated for the patient. Such orders must be countersigned by a responsible physician prior to the order being carried out.

G. Ancillary Services

Tests and procedures will be ordered at the discretion of the attending practitioner in the best interest of the individual patient and in keeping with good medical practice.

H. Medical Records

1. Medical records shall contain the following information as appropriate to the care and location of the patient:
 1. The patient's name, address, and date of birth, and the name of legally authorized representative
 2. The patient's sex
 3. The legal status of patient receiving behavioral health care services
 4. The patient's language and communication needs
 5. The reason(s) for admission for care, treatment, and services
 6. The patient's initial diagnosis, diagnostic impression(s), or condition(s)
 7. Findings of assessments and reassessments
 8. Allergies to food

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9. Allergies to medications
10. Conclusions or impressions drawn from the patient's medical history and physical examination
11. Diagnoses or conditions established during the patient's course of care, treatment, and services
12. Consultation reports
13. Observations relevant to care, treatment, and services
14. The patient's response to care, treatment, and services
15. Emergency care, treatment, and services provided to the patient before his or her arrival
16. Progress notes
17. All orders
18. Medications ordered or prescribed
19. Medications administered, including the strength, dose, and route
20. Access site for medication, administration devices used, and rate of administration
21. Adverse drug reactions
22. Treatment goals, plan of care, and revisions to the plan of care
23. Record of any clinical/research trials (drugs and devices) in which the patient is enrolled/participates.
24. Results of diagnostic and therapeutic tests and procedures
25. Medications dispensed or prescribed
26. Discharge diagnosis
27. Discharge plan and discharge planning evaluation
28. Operative or other high-risk procedure and/or the administration of moderate or deep sedation or anesthesia.
29. Advance directives
30. Informed consent, when required by policy (Informed Consent, BRD-04)
31. Records of communication with the patient, such as telephone calls or e-mail
32. Patient generated information/correspondence
33. Immunization Records
34. Patient problem (summary) list
35. Patient-identifiable records from outside providers
36. A patient who receives urgent or immediate care, treatment, and services:
 - a. The time and means of arrival
 - b. Indication that the patient left against medical advice, when applicable
 - c. Conclusions reached at the termination of care, treatment, and services, including the patient's final disposition, condition, and instructions given for follow-up care, treatment, and services
 - d. A copy of information made available to the practitioner or medical organization providing follow-up care, treatment, or services

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2. A history and physical examination shall be recorded within 24 hours of admission or prior to all surgery; this timeframe applies for weekend, holiday, and weekday admissions. This report shall include all pertinent findings resulting from an assessment of all systems of the body. If a complete history and physical has been performed within 30 days prior to admission, such as in the office of a physician staff member or, when appropriate, the office of a qualified oral-maxillofacial surgeon staff member, a durable, legible, authenticated copy of this report may be used in the patient's hospital medical record, provided there have been no changes subsequent to the original examination. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must be recorded at the time of admission. If a patient is readmitted for treatment of the same or a related problem within 30 days following discharge from the hospital, an interval history and physical examination report reflecting any subsequent changes may be used in the medical record, provided the original information is readily available.
3. The attending responsible for the care of the patient will authenticate the admission history and physical examination by countersignature of the note or signing a separate entry in the medical record that references a review of the document.
4. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and as frequently as the patient's condition requires, but in any case at intervals of 72 hours or less.
5. Operative reports shall include the name of the primary surgeon and assistants, findings, technical procedures used, specimens removed, and postoperative diagnosis. Operative reports shall be written or dictated immediately following surgery and the report promptly authenticated by the surgeon and made a part of the patient's medical record.
6. Consultations shall show evidence of a review of the patient's medical record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. When operative procedures are involved, the consultation note shall, except in emergency situations, so verified in the record, be recorded prior to the operation. If a consultation contains information of an especially sensitive and personal nature, the consultant may elect to omit such information from the consultation and note that the additional information is available to the practitioner requesting the consultation. A written permanent record of the

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complete consultation will be maintained in the appropriate departmental offices.

7. The medical staff must respond to all routine requests for consultations within 24 hours. If it is impossible to complete the consultation within 24 hours, the consultant must at least acknowledge the request and indicate his intentions so that the attending practitioner can plan disposition of the case without unnecessary prolongation of hospitalization. Urgent requests for consultation should be made by personal communication between the practitioner requesting the consult and the consultant.
8. All entries in the medical record will be timed, dated, the author identified, and authenticated. Authentication can include written signatures or initials, rubber stamp signatures, computerized authentication.
9. Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible practitioner at the time of discharge of all patients.
10. Within 30 days of discharge a clinical resume shall be written or dictated on all medical records of patients hospitalized over 48 hours (except patients with problems of minor nature whose stay is less than 48 hours). A final progress note documenting the patient's condition at discharge and completion of the Discharge Order and Summary Form may be substituted for the resume in the case of patients with problems of a minor nature who require less than a 48-hour period of hospitalization. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be authenticated by the responsible practitioner.
11. Written authorization of the patient is required for release of medical information to persons not otherwise authorized to receive this information.
12. Hospital medical records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All such records are the property of the hospital and shall not otherwise be taken away without permission of the Chief Medical Officer. In case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient is attended by the same practitioner or another.
13. Access to all medical records of all patients shall be afforded to members of the medical staff for study and research only in compliance with all applicable federal and state laws and regulations. Such access shall be consistent with preserving the

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confidentiality of personal information concerning the individual patients.

14. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Medical Record Committee.
15. Orders. Telephone or Verbal orders are to be accepted and written only by Licensed Registered Nurses and this should be limited to urgent circumstances. Exceptions: (1) Licensed Practical Nurses in the Emergency Department and Radiation Therapy Department working under the direct supervision of an RN or M.D., will be permitted to take a verbal order. (2) In emergency situations, telephone or verbal orders from a M.D. for respiratory procedures can be accepted and written by a respiratory therapist. (3) Dietitians who have taken verbal diet orders from a physician, limited to specific dietary orders. Each verbal order is dated and is identified by the names of the individuals who gave and received it. Orders written by acting interns (certain authorized medical students) must be countersigned by a licensed physician prior to the order being carried out. Orders written by other non-physician/dentists must be countersigned by a licensed attending practitioner before the nurse can carry out the order, unless otherwise approved by the Credentials Committee. (4) Licensed pharmacists may accept verbal/telephone orders for pharmaceuticals from physicians.
16. Only members of the service of an individual patient may write orders on that patient. Any orders written by consultants and other services must be countersigned. Exceptions to this rule are:
 - a. medications ordered by members of the Anesthesia Department in the PACU or ICU, and for pre-anesthetic medication; and
 - b. preoperative orders written by members of the Radiology Department.
 - c. orders written by the service of an individual patient stating orders from another service may be accepted.
17. Delinquent Charts: All members of the medical staff and house staff shall be required to complete their medical records in conjunction with the policies set forth by the Medical Records Committee and the Medical Executive Committee. All medical records will be completed within 30 days from the date of discharge. Failure to meet these policies will result in appropriate review. In those cases where review has determined that such failure exists without justification, disciplinary action may be taken.
18. Restraint and Seclusion Policies and Procedures will be established in consultation with the respective chairs of Departments and approved by the Chief Medical Officer.

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I: Midlevel Providers

(Physician Assistants / Nurse Practitioners/Certified Nurse Midwives)

A midlevel provider shall have graduated from a nationally accredited educational program or have been certified by a national certification board, and a physician assistant must be licensed by the North Carolina Medical Board, and a nurse practitioner or a certified nurse midwife must be approved by a Joint Subcommittee of the North Carolina Medical Board and North Carolina Board of Nursing and be licensed as a registered nurse with the North Carolina Board of Nursing. The midlevel provider shall conform to the rules and regulations of the medical staff with the following qualifications:

1. **RESPONSIBLE SUPERVISION:** A qualified member of the medical staff must at all times be responsible for the performance of the midlevel provider including compliance with supervision and quality improvement processes as described in the North Carolina Medical Practice Act and the North Carolina Administrative Code. The midlevel provider is responsible to this qualified medical staff member and for compliance with supervision and the quality improvement process being used by the physician-midlevel provider team.
2. **CREDENTIALING:** A qualified staff physician(s) who desires to utilize the services of a midlevel provider must submit the midlevel provider's credentials and a description of the proposed role, activities, and functions to be performed by the midlevel provider to the appropriate clinical department head. After approval by the appropriate clinical department head, said credentials and proposed role, activities, and functions must be approved by the Credentials Committee (Medical Executive Committee) of the hospital.
3. **IDENTIFICATION:** The midlevel provider in the hospital shall wear an identification badge or label plainly stating that he / she is a "PHYSICIAN ASSISTANT" or "NURSE PRACTITIONER" or "CERTIFIED NURSE MIDWIFE" in compliance with North Carolina Administrative Code.
4. **PRESCRIPTIVE AUTHORITY, DOCUMENTATION AND ENTRIES INTO MEDICAL RECORDS , AND AUTHORIZATION FOR ORDERS:**
Co-signatures are not required. Prescriptive Authority, Documentation, and Entries into Medical Records, and Authorization for Orders in the inpatient and outpatient areas shall be in compliance with Section 1 (Responsible Supervision).

J. Malpractice Insurance

Each member of the medical staff is required to have at least \$1,000,000/\$1,000,000 limits of coverage for liability insurance with a company licensed or approved by this state. All new members of the medical staff must submit (with their credentials requests)

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evidence that they have in force and effect, liability insurance as specified herein.

K. Required Immunities

Medical Staff members will comply with Medical Center Policy and CDC Guidelines for health care workers in preventing transmission of communicable diseases.

Approved by the Medical Executive Committee: April 11, 2011

Chair, Board of Directors
Wake Forest Baptist Medical Center

Chief Executive Officer
Wake Forest Baptist Medical Center

Chief Medical Officer
Wake Forest Baptist Medical Center

President and Chief Operating Officer of Health System
Wake Forest Baptist Medical Center